

FOR STATE
HEALTH DEPT.

02120

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02115

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Singing Hills, White Plains Md. c. LENGTH OF STAY IN lb 1-yr d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Star Route # 2. White Plains				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Singing Hills d. STREET ADDRESS Star Route # 2. White Plains e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWARD PERRY BAILEY First Middle Last				4. DATE OF DEATH 2 Month 4 Day 1967 Year			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 13-1942	
9. AGE (In years lost birthday) 25 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Major Elect.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Perry Bailey		14. MOTHER'S MAIDEN NAME Norine Shiplet		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Md. State Police, Waldorf, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 974X IMMEDIATE CAUSE (a) Hanging DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hanged self in basement of house		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 2-5-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 8-1967		23c. NAME OF CEMETERY OR CREMATORY Elk Run Cemetery		23d. LOCATION (City or Town) (County) (State) Elkton, Virginia	
24. FUNERAL DIRECTOR Simmons Bros., 1661 GOOD Hope Rd., S.E.		25a. REC'D BY REGISTRAR FEB 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		26. ADDRESS Wash., D.C.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02121

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02116

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY CHARLES		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah 081	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Arehart Funeral House			d. STREET ADDRESS		
3. NAME OF DECEASED First Middle Last Edward Lee BROWN (Type or print)			4. DATE OF DEATH Month Day Year February 18, 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/12		9. AGE (In years last birthday) xx54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber Yard		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME George Lee Brown		
14. MOTHER'S MAIDEN NAME Nina Taxton			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Hawkins Funeral Home, Charlottesville, Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute ethylism					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Russell S. Fisher		M.O. Russell S. Fisher, M.D.		22. DATE SIGNED February 20, 1967	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/22/67	23c. NAME OF CEMETERY OR CREMATORY Wildrose Cemetery		23d. LOCATION (City or Town) (County) (State) Batesville, Va.	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR FEB 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02122

CERTIFICATE OF DEATH

02117

1. PLACE OF DEATH o. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laplata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryantown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physician Memorial Hospital		d. STREET ADDRESS P.O. Box 23	
3. NAME OF DECEASED (Type or print) Mary Rose Butler		4. DATE OF DEATH FEBRUARY 16 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1882
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-34-7146	
17. INFORMANT Joseph Butler Box 23 Bryantown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/13 , 19 67 , to 2/16 , 19 67 , that (I) (we) last saw the deceased alive on 2/16 , 19 67 , and that death occurred at 2:35 AM , from causes and on the date stated above.			
22a. SIGNATURE Arturo M. Monteiro		22b. DATE SIGNED 2/18/67	
22c. PHYSICIAN'S NAME (Type) Arturo M. Monteiro		22d. ADDRESS LA Plata, Md. Charles	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 20, 1967	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Bryantown, Chas. Co. Md.	
24. FUNERAL DIRECTOR Martell Adams		25a. REC'D BY REGISTRAR Aguasco, Maryland	
25b. REGISTRAR'S SIGNATURE Charles George		DATE FEB 27 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02118

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fenwick			c. LENGTH OF STAY IN 1b Fenwick			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fenwick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bryans Rd.				d. STREET ADDRESS Box 177 Bryans Road			
3. NAME OF DECEASED (Type or print) John Edward Driver				4. DATE OF DEATH Month 2 Day 13 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1899		9. AGE (In years lost birthday) yrs. 67		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eng. & Machinest			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John E. Driver			14. MOTHER'S MAIDEN NAME Susie ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address George Driver 3412 Cheverly Ave. Chev. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 2/14/67	
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb. 16, 1967		23c. NAME OF CEMETERY OR CREMATORY Epiphany Church Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd., Suitland, Maryland				25a. REC'D BY REGISTRAR DATE FEB 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02124

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02119

1. PLACE OF DEATH a. COUNTY <u>C HAS</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
c. LENGTH OF STAY IN 1b <u>Visiting</u>		d. STREET ADDRESS <u>1425 Potomac Ave NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laplace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCIS X</u>		4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 8 - 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elect. & Nat. Man Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>	
13. FATHER'S NAME <u>Edward D. Flaherty</u>		14. MOTHER'S MAIDEN NAME <u>Margaret M. Rathmund</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margaret M. Nelson</u>		Address <u>33 - Pennsylvania Ave NW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>17-67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Sweeping Snow off Auto</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> p.m. <u>3</u> <u>19</u> <u>67</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>WASH DC</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E J. EDELEN</u>		22. DATE SIGNED <u>2-19-67</u>	
EXAMINER'S NAME (Type) <u>E J. EDELEN</u>		Address (Street, city, town, or county) <u>DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>1661- Good Hope Road SE, Wash., DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 23 1967</u>			

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01150

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FOR STATE
HEALTH DEPT.

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VR A15ME (3)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G386 3/2/67 mh

02125

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02120

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Chas.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Southgate</u>				c. LENGTH OF STAY IN lb <u>15 min</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Phys Rem Hosp</u>				d. STREET ADDRESS <u>Navy Emory</u>			
3. NAME OF DECEASED (Type or print) <u>WALTER</u> First Middle Last				4. DATE OF DEATH <u>HANCOCK</u> Month <u>2</u> Day <u>-26</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-9/21</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charles Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John T. Hancock</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Tubman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Maria Barber</u> Address <u>Charles Co. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>C.O.A.</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2-26-67</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. E. DeLena</u> M.D.				22. DATE SIGNED <u>2-26-67</u>			
EXAMINER'S NAME (Type) <u>E. E. DeLena</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Baptist Church</u>		23d. LOCATION (City or Town) (County) (State) <u>Charles Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Montgomery Bros Inc.</u> ADDRESS <u>714 Kennedy St NW Wash, D.C.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

08180

08180

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05071

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Arehardt Funeral Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clif Henderson		4. DATE OF DEATH Month 2 Day 20 Year 1967	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 65 yrs.
9. AGE (In years lost birthday)		10. IF UNDER 1 YEAR Months 20 Days 19 Hours 67 Min.	11. IF UNDER 24 HRS. Months 20 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive spontaneous intra-cerebral hemorrhage DUE TO (b) 331A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 2/2/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL CREMATION REMOVAL (Specify)	23b. DATE THEREOF 4-6-67	23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR DATE APR 18 1967	25b. REGISTRAR'S SIGNATURE Charles Yuage

0507

APR 18 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																
02126					CERTIFICATE OF DEATH					02121						
1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LaPlata Md c. LENGTH OF STAY in 1b 9-days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial LaPlata Md					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rison-Rt-1 Md Rural d. STREET ADDRESS 081 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Adele Hoffman					4. DATE OF DEATH Month 2 Day 27 Year 1967											
5. SEX F.		6. COLOR OR RACE W-US		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-29-1915		9. AGE (In years last birthday) 54 52 yrs.		IF UNDER 1 YEAR Months 54 Days 52		IF UNDER 24 HRS. Hours 54 Min. 52				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mulco Products					10b. KIND OF BUSINESS OR INDUSTRY Manufacturing					11. BIRTHPLACE (County & State, or foreign country) Altengurg-Mo					12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul Funderlich					14. MOTHER'S MAIDEN NAME Maggelina Heins											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 498-24-3051					17. INFORMANT Husband-Otto Hoffman Address Rison Md						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis Carcinoma- Uterine 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Uterus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia and Malnutrition										INTERVAL BETWEEN ONSET AND DEATH 2-Yrs 2-Yrs						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 6-1-1964 , 19 1967 , that (I) (we) last saw the deceased alive on 2-27-1967 19 1967 , and that death occurred at 10-05 PM on the causes and on the date stated above.																
22a. SIGNATURE James E. Andrews M.O. 2-28-1967										22b. DATE SIGNED 2-28-1967						
22c. PHYSICIAN'S NAME (Type) James E. Andrews MD					22d. ADDRESS Indian Head Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 3/2/1967		23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens			23d. LOCATION (City, town or county) (State) Waldorf, Md.						
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.					ADDRESS DATE					25a. REC'D BY REGISTRAR MAR 3 1967 25b. REGISTRAR'S SIGNATURE Charles Judge						

13130

03130



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02127

CERTIFICATE OF DEATH

02122

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>		081	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial Hosp.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Teresa</u> Middle <u>Istvan</u> Last <u>Istvan</u>				4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23 1879</u>	9. AGE (In years last birthday) yrs. <u>87</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u>		IF UNDER 24 HRS. Hours <u>8</u> Min. <u>8</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (County & State or foreign country) <u>Yugoslavia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Sherer</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hornung</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Leo Istvan, Hughesville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL CARCINOMA</u> <u>1531</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Ca. of Hepatic Flexure.</u> (c) <u>6 weeks</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/22</u> , 19 <u>67</u> , to <u>2/5</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Feb. 5</u> , 19 <u>67</u> , and that death occurred at <u>2:15 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Arturo M. Monteiro</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arturo M. Monteiro</u>				22d. ADDRESS <u>La Plata, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		23d. LOCATION (City or Town) (County) (State) <u>Bryantown, Chas. Md.</u>	
24. FUNERAL DIRECTOR <u>The Hunt Funeral Home, Waldorf, Md.</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>gcharles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08188

RECORDS OF CIVIL

08188

RECEIVED
JAN 10 1964
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02128

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02123

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicans Memorial Hospital		d. STREET ADDRESS 08-1	
3. NAME OF DECEASED (Type or print) First IRVING Middle PENN Last JOHNSON		4. DATE OF DEATH Month February Day 22 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1941
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9b. KIND OF BUSINESS OR INDUSTRY Coca-Cola Bottling	9c. AGE (In years last birthday) yrs. 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Coca-Cola Bottling	10c. BIRTHPLACE (State or foreign country) Charles Co., Md.
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benedict Johnson		14. MOTHER'S MAIDEN NAME Irene Mary Lyles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-38-4931	
17. INFORMANT Mrs. Alice E. Johnson-Wife		Address Box 267A Waldorf,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 223X DUE TO (b) po cerebral and spinal DUE TO (c) involvement		INTERVAL BETWEEN ONSET AND DEATH 1966	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. J. Edelen M.D.		22. DATE SIGNED 2-22-67	
EXAMINER'S NAME (Type) E. J. Edelen, MD. La Plata, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/25/1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Bryantown, Maryland
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. La Plata, Md.		25a. REC'D BY REGISTRAR FEB 28 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

85130

85130

Handwritten signature

1985

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02129

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02124

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CITAS</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laplaton, D.O. Co.</u>		d. STREET ADDRESS <u>RT-1-Box 450-Waldorf</u>	
3. NAME OF DECEASED (Type or print) <u>BENJAMIN</u> First <u>HENRY</u> Middle <u>JOY</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-15</u>
		9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teach Dance</u>	11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>
13. FATHER'S NAME <u>Henry L. Joy</u>		14. MOTHER'S MAIDEN NAME <u>Georgiana Tucker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>100-111111</u>	
17. INFORMANT <u>Dorothy Joy (wife)</u> Address <u>Same as</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Constrictive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Hypertension</u> (b) <u>?</u> (c) <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Chronic</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.O.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>[Signature]</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>2-15-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery - Arlington, Virginia</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Simmons Bros.</u> ADDRESS <u>1661- Gd. Hope Road SE. Wash. DC</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>
OAT <u>FEB 16 1967</u>			

08150

08150

02130

CERTIFICATE OF DEATH

02125

1. PLACE OF DEATH a. COUNTY <u>Charles County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHAS.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Malcolm</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRADYLINE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Rt #1 Box 862</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MORTON</u> Middle <u></u> Last <u>MONROE</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Charles County</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Aline-Sewell Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Jane Slater</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Brandywine, Maryland</u> <u>Aline Sewell Rt. 1 Box 284</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis</u> <u>002.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Malnutrition</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/24</u> , 19 <u>67</u> , to <u>1/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 5</u> , 19 <u>67</u> , and that death occurred at <u>3:45</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>Arturo M. Monteiro</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arturo M. Monteiro</u>				22d. ADDRESS <u>111 Plata, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 9/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Philip's Church</u>		23d. LOCATION (City or Town) (County) (State) <u>Aguasco Pr. Geo. Md.</u>	
24. FUNERAL DIRECTOR <u>Martell Adams Aguasco, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08150

STATE OF DEATH

08150

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		RELIGION	
MARRIAGE		OCCUPATION	
EDUCATION		MILITARY SERVICE	
HUSBAND'S NAME		WIFE'S NAME	
CHILDREN'S NAMES		SISTER'S NAMES	
BROTHER'S NAMES		PARENTS' NAMES	
GRANDPARENTS' NAMES		OTHER RELATIVES' NAMES	
CAUSE OF DEATH		PLACE OF DEATH	
MANNER OF DEATH		CERTIFICATE NO.	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
SIGNATURE OF JUDGE		SIGNATURE OF NOTARY	
SIGNATURE OF CORONER		SIGNATURE OF SHERIFF	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF SECRETARY OF STATE	
SIGNATURE OF GOVERNOR		SIGNATURE OF PRESIDENT	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02131

CERTIFICATE OF DEATH

02126

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>62 PHYSICIANS MEMORIAL HOSP.</u>				d. STREET ADDRESS <u>RFD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA MAHALA PICKERAL</u>				4. DATE OF DEATH Month Day Year <u>FEBRUARY 7 1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1886</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM ATCHINSON</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>LILLIAN PICKERAL, WALDORF MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic heart disease.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>metastatic cancer</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fall</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/31</u> , 19 <u>67</u> , to <u>2/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> , 19 <u>67</u> , and that death occurred at <u>5:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. J. M. Monteiro</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. J. M. Monteiro</u>		22d. ADDRESS <u>La Plata, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-11-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST PETERS Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>WALDORF CHARLES MD.</u>	
24. FUNERAL DIRECTOR <u>HUNTT FUNERAL HOME, WALDORF, MD</u>				25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03150

WORLD D. 03150

03150

03150

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02132

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02127

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville c. LENGTH OF STAY IN lb 05-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville d. STREET ADDRESS 05-1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM First HENRY Middle SMALLWOOD Last		4. DATE OF DEATH Month 2 Day 18 Year 1967	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1917
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	9. AGE (In years last birthday) 49 yrs.
11. BIRTHPLACE (State or foreign country) Prince George C., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George A. Smallwood		14. MOTHER'S MAIDEN NAME Betty McGruder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Arthur Smallwood		Address Port Tobacco, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cong Heart Failure DUE TO (b) Pericardial Pneumony DUE TO (c) tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1767 2 years known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. J. Edele EXAMINER'S NAME (Type) E. J. EDELEN M.D.		22. DATE SIGNED 2-18-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY John Wesley		23d. LOCATION (City or Town) (County) (State) Aquasco, Prince George, Maryland	
24. FUNERAL DIRECTOR Arehart Funeral Home Inc., La Plata, Md.		25a. REC'D BY REGISTRAR Feb 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

03137

03137

02133

CERTIFICATE OF DEATH

02128

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Issue 08-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicans Memorial Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Camille Rae Bumb SMOTHERS		4. DATE OF DEATH Month Day Year Feb 24 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1967
9. AGE (In years lost birthdays) yrs. 1		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) La Plata, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fredrick Coren Bumbry		14. MOTHER'S MAIDEN NAME Emma Jean Smothers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. John W. Smothers-Grandfather		Address Issue, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7730 Glycine membrane disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 18 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-24 , 19 67 , to _____, 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that death occurred at 3 P.M. , from causes and on the date stated above.			
22a. SIGNATURE F.M. Johnson		22b. DATE SIGNED 2-25-67	
22c. PHYSICIAN'S NAME (Type) F.M. JOHNSON M.D.		22d. ADDRESS LA PLATA, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/25/1967	23c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery	23d. LOCATION (City or Town) (County) (State) Issue, Maryland
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. - La Plata, Md.		25a. REC'D BY REGISTRAR DATE MAR 1 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08130

EXHIBIT OF 08130

08130

1. NAME OF PARTY		2. ADDRESS	
3. OCCUPATION		4. DATE OF BIRTH	
5. SEX		6. MARITAL STATUS	
7. EDUCATION		8. RELIGION	
9. ETHNICITY		10. NATIONALITY	
11. SOCIAL CLASS		12. INCOME	
13. EMPLOYMENT		14. RESIDENCE	
15. CONTACT INFORMATION		16. SIGNATURE	
17. DATE		18. OFFICIAL USE	

FOR STATE
HEALTH DEPT.

02134

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02129

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf 08-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last ETHEL MAE STEWART		4. DATE OF DEATH Month Day Year February 10 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 11, 1939
9. AGE (In years lost birthday) 27 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH H. STEWART		14. MOTHER'S MAIDEN NAME AGNES STEWART	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple stab wounds 982X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) Stabbed during altercation	
20c. TIME OF INJURY Month, Day, Year Hour, min. p.m. 2-10 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parking lot		20f. (City or town) (County) (State) Waldorf Charles Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		22. DATE SIGNED 2/12/67	
EXAMINER'S NAME (Type) Charles S. Petty		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE THEREOF 2-13-67		23c. NAME OF CEMETERY OR CREMATORY ST PETERS CEM.	
23d. LOCATION (City or Town) (County) (State) WALDORF, MD.		24. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE FEB 16 1967			

08180

08180



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02135

CERTIFICATE OF DEATH

02130

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b WHITE PLAINS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PHYSICIANS MEMORIAL		d. STREET ADDRESS 081	
3. NAME OF DECEASED (Type or print) First LOTTIE Middle L. Last WATSON		4. DATE OF DEATH Month FEB Day 22 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 27, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	9. AGE (In years lost birthday) 69 yrs.
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT DAVIS		14. MOTHER'S MAIDEN NAME CATHERINE COLLINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT FRED E. WATSON, WHITE PLAINS, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5810 IMMEDIATE CAUSE (a) Acute gastrointestinal hemorrhage DUE TO (b) Cirrhosis of the liver DUE TO (c) 2 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-21 , 19 67 , to 2-22 , 19 67 , that (I) (we) last saw the deceased alive on 2-21 , 19 67 , and that death occurred at 1A M, from causes and on the date stated above.			
22a. SIGNATURE F. M. Johnson MD		22b. DATE SIGNED 2-22-67	
22c. PHYSICIAN'S NAME (Type) F. M. JOHNSON MD		22d. ADDRESS LA PLATA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2-25-67	23c. NAME OF CEMETERY OR CREMATORY Bumpy Oak Cem.	23d. LOCATION (City or Town) (County) (State) Pomonkey, CHARLES, MD.
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR FEB 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06150

66190

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 8 Film G386 2/24/67 mh									
02136									
CERTIFICATE OF DEATH									
Reg. Dist. No. 02131									
1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CHARLES</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POMFRET</u>			d. STREET ADDRESS <u>18-1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PHYSICIANS MEMORIAL HOSP</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>HYDRICK B</u> First <u>WELCH</u> Middle <u>WELCH</u> Last					4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1967</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAU.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-17-1919</u>		9. AGE (In years last birthday) <u>47</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FUEL OIL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>BRYAN WELCH</u>					14. MOTHER'S MAIDEN NAME <u>GERTRUDE CHING</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WWII</u>					16. SOCIAL SECURITY NO. <u>214-18-8475</u>				
17. INFORMANT <u>ANNA WELCH</u>					Address <u>POMFRET, MD.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ART SCLEROTIC HT DIS.</u> DUE TO (c) <u>12-5-1966</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2-6-67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-2-56</u> , to <u>1-23-67</u> , that I last saw the deceased alive on <u>1-23-67</u> , and that death occurred at <u>HP M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>LA PLATA, MD.</u> DATE SIGNED <u>2-7-67</u> ACTUAL SIGNATURE <u>E. J. EDELEN</u> M.D. PHYSICIAN'S NAME (Type) <u>E. J. EDELEN</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)		
<u>BURIAL</u>		<u>2-10-67</u>		<u>ST JOSEPH'S CEM.</u>			<u>POMFRET, MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT FUNERAL HOME, WILDORE, MD.</u>					24a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>		

05151

CERTIFICATE OF DEATH

05151

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF BIRTH: *Jan 1, 1920*

5. PLACE OF BIRTH: *Baltimore, Md.*

6. OCCUPATION: *Teacher*

7. CAUSE OF DEATH: *Heart Disease*

8. DATE OF DEATH: *Dec 15, 1965*

9. PLACE OF DEATH: *Home*

10. SIGNATURE OF PHYSICIAN: *Dr. J. K. Smith*

11. SIGNATURE OF REGISTRAR: *John Doe*

12. SIGNATURE OF WITNESS: *John Doe*

13. SIGNATURE OF WITNESS: *John Doe*

14. SIGNATURE OF WITNESS: *John Doe*

15. SIGNATURE OF WITNESS: *John Doe*

16. SIGNATURE OF WITNESS: *John Doe*

17. SIGNATURE OF WITNESS: *John Doe*

18. SIGNATURE OF WITNESS: *John Doe*

19. SIGNATURE OF WITNESS: *John Doe*

20. SIGNATURE OF WITNESS: *John Doe*

21. SIGNATURE OF WITNESS: *John Doe*

22. SIGNATURE OF WITNESS: *John Doe*

23. SIGNATURE OF WITNESS: *John Doe*

24. SIGNATURE OF WITNESS: *John Doe*

25. SIGNATURE OF WITNESS: *John Doe*

26. SIGNATURE OF WITNESS: *John Doe*

27. SIGNATURE OF WITNESS: *John Doe*

28. SIGNATURE OF WITNESS: *John Doe*

29. SIGNATURE OF WITNESS: *John Doe*

30. SIGNATURE OF WITNESS: *John Doe*

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36. SIGNATURE OF WITNESS: *John Doe*

37. SIGNATURE OF WITNESS: *John Doe*

38. SIGNATURE OF WITNESS: *John Doe*

39. SIGNATURE OF WITNESS: *John Doe*

40. SIGNATURE OF WITNESS: *John Doe*

41. SIGNATURE OF WITNESS: *John Doe*

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43. SIGNATURE OF WITNESS: *John Doe*

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97. SIGNATURE OF WITNESS: *John Doe*

98. SIGNATURE OF WITNESS: *John Doe*

99. SIGNATURE OF WITNESS: *John Doe*

100. SIGNATURE OF WITNESS: *John Doe*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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BP

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02137

CERTIFICATE OF DEATH

02132

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF 08-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PHYSICIANS MEMORIAL				d. STREET ADDRESS RT2 BOX 131		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE M WILLETT				4. DATE OF DEATH Month Day Year FEB. 16, 1967			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-1-1892	
9. AGE (In years lost birthday) 74 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (County & State, or foreign country) CHARLES, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MARCELLUS WILLETT		14. MOTHER'S MAIDEN NAME ADELINE PICKERAL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address JOHN WILLETT, RT2, BOX 131, WALDORF, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CONGESTIVE HEART FAILURE DUE TO (c) MYOCARDIAL ISCHEMIA							INTERVAL BETWEEN ONSET AND DEATH 5 days 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 FEB , 19 67 , to 16 FEB , 19 67 , that (I) (we) last saw the deceased alive on 16 FEB , 19 67 , and that death occurred at 1:45 P.M. , from causes and on the date stated above.							
22a. SIGNATURE J. Barry Mason M.D.				22b. DATE SIGNED 17 Feb 67		22c. PHYSICIAN'S NAME (Type) J. G. Barry Mason M.D.	
22d. ADDRESS LA PLATA MARYLAND 20646							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-18-67		23c. NAME OF CEMETERY OR CREMATORY OAKLAND Cem.		23d. LOCATION (City or Town) (County) (State) WALDORF, MD.	
24. FUNERAL DIRECTOR ADDRESS HUNTT FUNERAL HOME, WALDORF, MD.				25a. REC'D BY REGISTRAR FEB 21 1967		25b. REGISTRAR'S SIGNATURE J. Charles Mason	

68183

RECEIVED OF DEATH

68183

68183

TO RECUSSION AT BUREAU OF RECORDS

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02138

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02133

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Rt. 3	
3. NAME OF DECEASED (Type or print) JOHN D YATES		4. DATE OF DEATH 2-20-67	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-20-96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unkown	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Henry Yates		14. MOTHER'S MAIDEN NAME Emily Craig	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-18-1038	
		17. INFORMANT Address Agnes Yates, Rt. 3, La Plata, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4341 IMMEDIATE CAUSE (a) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Obstructive Pulmonary Disease (c) Chronic Bronchitis		INTERVAL BETWEEN ONSET AND DEATH 2-20-67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. J. Edele		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. EDELEN		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED 2-20-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 22, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Ignatius
		23d. LOCATION (City or Town) (County) (State) Chapel Point, Charles, Md.	
24. FUNERAL DIRECTOR Arehart Funeral Home Inc., La Plata, Md.		25a. REC'D BY REGISTRAR FEB 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

05138

05138



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02139

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02134

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryantown		c. LENGTH OF STAY IN lb Bryantown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Charles DeSales Young		4. DATE OF DEATH Month 2 Day 7 Year 1967	
5. SEX M	6. COLOR OR RACE E	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	9. AGE (In years last birthday) yrs. 70
11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Alfred Young		14. MOTHER'S MAIDEN NAME Ida Marshall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 062-14-8740	
17. INFORMANT Mrs. Sally Ann Johnson-Sister		Address Bryantown, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9129 IMMEDIATE CAUSE (a) Crushing injury to chest DUE TO (b) 2-7-67 DUE TO (c) 2-7-67			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED 3 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. J. Edelen M.D.		22. DATE SIGNED 2-7-67	
EXAMINER'S NAME (Type) E. J. Edelen, M.D.		La Plata, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/1967	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Bryantown, Maryland	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.		ADDRESS	
25a. REC'D BY REGISTRAR FEB 16 1967		25b. REGISTRAR'S SIGNATURE Charles Young	

48180

2818